MDR Tracking Number: M5-05-1489-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-20-05.

The IRO reviewed office visits, chiropractic manipulations, massage, electrical stimulation, therapeutic exercises, therapeutic activities, diathermy, and mechanical traction from 1-21-04 to 2-25-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 2-25-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Rule 134.202 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service.

The requestor billed code 97750-MT for date of service 1-30-04. The modifier –MT is invalid for dates of service after 8-1-03 and will not be reviewed. Therefore, no reimbursement can be recommended.

Codes 98940, 97124, 99213, G0283, 97012, 97024 billed for dates of service 3-5-04 and 3-8-04 had no EOBs submitted by either party. Per Rule 133.308(f)(3), the requestor submitted convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, this will be reviewed per Rule 134.202(c). Recommend reimbursement as follows:

Code 98940 - MAR is $25.08 x 125% = $31.35 x 2 days = $62.70
Code 97124 - MAR is $21.02 x 125% = $26.27 x 2 days = $52.54
Code 99213 - MAR is $49.58 x 125% = $61.97 x 2 days = $123.94
Code G0283 - MAR is $10.73 x 125% = $13.41 x 2 days = $26.82
Code 97012 - Mar is $14.33 x 125% = $17.91 x 2 days = $35.82
Code 97024 - MAR is $5.59 x 125% = $6.98 x 2 days = $13.96

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 3-5-04 and 3-8-04 as outlined above in this dispute.

This Order is hereby issued this 31st day of March 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

Forté

7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Original Date: March 24, 2005

Amend Date: March 28, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:
MDR Tracking #: M5-05-1489-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Daily notes
- Initial narrative reports
- Subsequent medical reports
- FCE reports
- Designated doctor report

Submitted by Respondent:

- Peer review report

Clinical History

According to the supplied documentation, it appears the claimant sustained an injury on ___ when he was pulling a dolly up steps. The claimant reported pain in his neck, head, right forearm and low back. The claimant reported to Ron Linderman, D.C. on 11/4/03 for evaluation. Dr. Linderman diagnosed the claimant with a neck sprain/strain, a lumbar sprain/strain, a right wrist sprain/strain and a lumbar facet syndrome. The claimant began active and passive physical medicine. An FCE was performed on 3/1/04 which reported the claimant was not able to work at his prior physical demand level and was recommended for a work hardening program. On 3/5/04 the claimant was seen at Hillcrest Chiropractic Center with Shawn A. Fyke, D.C. for a designated doctor exam. Dr. Fyke reported that the claimant was at MMI on 2/23/04 with a whole person impairment of 6%. The documentation ends here.

Requested Service(s)

Office visits (99212 and 99213), chiropractic manipulation (98940 and 98941), massage (97124), electrical stimulation, unattended (G0283), therapeutic exercises (97110), therapeutic activities (97530), diathermy (97024), mechanical traction (97012) for dates of service 1/21/04 to 2/25/04 and 3/12/04.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the initial medical report by Dr. Linderman, the claimant was diagnosed with a sprain/strain. The supporting documentation that is supplied for review does not support any diagnosis greater than that of a neck, lumbar and wrist sprain/strain. The initial 6-8 weeks of therapy appear reasonable and medically necessary to treat the compensable injury, but at that time it would be necessary to either modify the therapy or refer for an orthopedic consult. Continued and ongoing passive and active therapies beyond the initial 2 months is not seen as reasonable or medically necessary to treat the compensable work injury. According to the Official Disability Guidelines (page 1138) chiropractic guidelines for a severe sprain/strain and with evidence of objective functional improvement a total of 18 visits over a 6-8 week period is seen as reasonable and medically necessary. The frequency of care beyond the initial 2 months did not appear to fade while there is no evidence of a home based exercise program being implemented. The documentation does support that the claimant was told to begin a home based exercise program on the very first date of treatment on 11/4/03, but no documentation provided an emphasis on this beyond that date. None of the treatment on the table of services is considered reasonable or medically necessary to treat the compensable work injury.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 28th day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder